21ST CENTURY INTERNATIONAL INSTITUTIONS: LESSONS FROM GLOBAL HEALTH GOVERNANCE?

This panel was convened at 10:45 am, Friday, April 5, by its moderator, Benedict Kingsbury of New York University Law School, who introduced the panelists: Gian Luca Burci of the World Health Organization; Jacob Katz Cogan of the University of Cincinnati College of Law; David Gartner of Sandra Day O'Connor College of Law, Arizona State University; and Jennifer Prah Ruger of Yale University's School of Medicine and Law School.

Coordination in Global Health and Its Costs

By Jacob Katz Cogan[*]

Just as health problems cross borders, they also range widely across the competences of the organizations that have as their aim the provision of health services and the improvement of health outcomes—whether those organizations are international institutions, governments, private-sector bodies, or civil society groups. For any particular problem, multiple organizations may have separate capabilities that when put together might, more efficiently and effectively, solve or ameliorate health problems. While coordination and cooperation among many public and private, international and national, organizations have always been recognized at some level as important, the challenges and opportunities presented today in global health are unique, and hence the coordination imperative has become even greater. As a consequence, experimentation in the structures of organizational cooperation has been considerable.

Here, I very briefly focus on three points pertaining to contemporary coordination and cooperation in global health: why it is that the commitment to coordination is greater now than in the past; the variety of organizational means employed for the achievement of such coordination; and the challenges that stem from coordination.

The Idea of Coordination

Coordination has always been an issue in international organization. It arises from the fact that the international system is a decentralized one operating at three levels. It is decentralized because all states are considered equal, each with sovereign authority and hence sovereign control over and responsibility for their own populations, including their welfare. It is decentralized at the nongovernmental level because private actors mobilize in response to certain perceived needs in their community, whether that community is local or global. And it is decentralized at the intergovernmental level. This is as much by design as by inevitability. At its founding, the idea that the United Nations might act as *the* central international organization, inclusive of all topics, was purposely rejected and instead what we now know as the family of specialized agencies was adopted. Those agencies, the World Health Organization among them, entered into relationship agreements with the UN—but these were weak. For the most part they concerned information exchanges and coordination of administrative and technical services, as well as budgetary consultations. Despite the Charter's provision in Article 58 that the UN ''shall make recommendations for the coordination of the polices and activities of the specialized agencies,'' and despite attempts by ECOSOC to implement

[*] Judge Joseph P. Kinneary Professor of Law, University of Cincinnati College of Law.

https://doi.org/10.5305/procannmeetasil.107.0259 Published online by Cambridge University Press

this provision over the years, the independence of the specialized agencies—each with its own membership and secretariat, each jealous of its own authorities—typically has limited such coordination.

Remarkably, the idea that international coordination is critically important has only arisen within the past two decades. In the area of health, this new understanding stemmed from an increased expectation concerning the ''right [of individuals] to have [their] basic health needs met,''[1] from the realization that health issues (particularly in an age of vast increases in interstate trade and the movement of persons) are matters of transnational scope, and from the increase in the number and diversity of actors seeking to promote their health agendas and priorities. The plethora and variety of programs and actors that fund and implement health initiatives has led to confusion, competition, and duplication of effort. This is a vastly different world from that of the Cold War, when the number of actors was much fewer and the activity was primarily (if not exclusively) governmental (that is, limited generally to states and traditional international organizations).[2]

It is not surprising that coordination's salience would be historically contingent in this way. Coordination as a value must have considerable resonance for it to overcome the centrifugal force common to the international system. Whether the coordination idea has traction in the work and the agendas of relevant actors will change over time. While talk of coordination has long been around, the operationalization of that commitment has not always occurred—but that appears to have changed in recent years.

The Mechanisms for Coordination

In response to this desire for coordination, global health actors have designed different coordination structures, which, seen together, operate along a continuum of organizational formality.

One way in which coordination has taken place is through the establishment of new formal international organizations that focus on a single issue or set of issues. These new organizations act as clearinghouses for other, established organizations, gathering resources together and streamlining their distribution. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunisation (GAVI) are examples.

A second way is to focus on particular subjects through the establishment of partnerships. These are attempts to institute coordinated activity through collaborations that fall short of the creation of formal organizations. Such partnerships are housed within existing international organizations and supported by existing secretariats.

This partnership concept is not new, at least in its basic form. Earlier initiatives were fairly simple schemes though, at least in terms of the number of organizations participating in the collaboration. By the 1990s, partnerships would become more elaborate and complicated, incorporating the work of many organizations, such as with the establishment of UNAIDS.

A more recent example is the International Health Partnership, which was established in 2007 to accelerate progress on the health Millennium Development Goals. It now includes more than fifty partners, including thirty developing countries, donor countries, and development agencies. The IHP's idea is to coordinate development assistance for health by establishing a single health strategy.

[1] Mark L. Rosenberg, Elisabeth S. Hayes, Margaret H. McIntyre & Nancy Neill, Real Collaboration: What It Takes for Global Health to Succeed 23 (2010).

[2] The WHO's 1946 constitution specified that the organization's functions include ''to act as the directing and coordinating authority on international health work.'' WHO Constitution art. 2(a); *see also id.* art. 2(b).

A second recent example is the Global Health Cluster, established by the Inter-Agency Standing Committee, which is a mechanism established by the United National General Assembly in 1991 to ''bring[] together international organizations working to provide humanitarian assistance to people in need as a result of natural disasters, conflict-related emergencies, global food crises and pandemics.'' The aim of the Committee's Cluster Approach, which was designed in 2005 and 2006, is ''to strengthen system-wide preparedness and technical capacity to respond to humanitarian emergencies by ensuring that there is predictable leadership and accountability in all the main sectors or areas of humanitarian response.''[3] The Global Health Cluster, which is led by the WHO and includes thirty-seven other partner agencies and organizations, ''serves as a mechanism for coordinated assessments, joint analyses, the development of agreed overall priorities, objectives and a health crisis response strategy.''

This range of organizational forms and their internal structures reflects the level of commitment to the idea of collaboration. Collaboration does not entail a specific organizational architecture or set of relationships; rather, there is a continuum of commitment to the collaboration idea and the forms of organization are a manifestation of that commitment. Each choice and each design reflects a negotiation among the potential partners that allows them to work collectively to achieve a common goal without forsaking their individual mandates.

The Challenges and Costs of Coordination: Layering and Uniformity

This creativity and experimentation in organizational design is all done for very good reasons. One can be skeptical of particular aspects, but it is important to place that criticism within a context that does not ignore the consequences stemming from the absence of coordination or the challenges of cooperation. In that spirit, two points might be made:

First, the act of coordination involves organizational layering. Organizations, by joining together, create new programs or organizations, governed by their creators. Thus, for example, UNAIDS is cosponsored by eleven UN organizations; put another way, it is an organization layered on top of other organizations, which themselves are layered on top of governments. What does this layering do to the accountability of organizations? What does this layering do to the legitimacy of an organization when the sources of its popular authority are so severely attenuated? Who benefits from such attenuation? Civil society representation in decisionmaking bodies, which is not unusual in health organizations, including UNAIDS, does not solve the layering problem. The attenuation is still there, although its manifestation is different.

Second, the act of coordination creates the risk of uniformity. The idea of coordination is to generate efficiencies, which requires not just logistical synchronicities but policy agreements as well. In other words, coordination and competition are often at odds. Coordination seeks to remedy the downsides of competition, but the costs of coordination are competition's benefits, particularly innovation.

These are some of the challenges of coordination, and the participants in these ventures are well aware of them. Many have taken measures, which I cannot go into here, to enhance their accountability and legitimacy and to meliorate potential downsides. But while such measures are important, in the area of global health, as elsewhere, we might just have to

[3] Inter-Agency Standing Committee, IASC Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response, Nov. 24, 2006.

live with the transaction costs of coordination. Our willingness to bear those costs will test our commitment to the idea of coordination itself.

Remarks by Gian Luca Burci*

Global health has been one of the fields of international relations and law where governments and other stakeholders have engaged in institutional experimentation in the last twenty years, leading the development of new concepts of international governance and policymaking away from traditional assumptions about international institutions and development cooperation.

Among the political reasons underpinning this trend is the ''retreat of the state'' in public health, with a shrinking public regulatory space and with health policy and services increasingly entrusted to private actors. At the international level this translates to decreased confidence in traditional international organizations, with nongovernmental stakeholders filling the governance gap and demanding full participation and legitimacy. Another consideration is the persistent contradiction between the political attention and financial resources devoted to health, on the one hand, and the perceived failure of current trade and market rules in securing the development of, and access to, essential medical products, on the other hand. Many if not all of the initiatives under consideration represent efforts to address such an unforgivable failure.

Recent trends in international public health show a preference for hybrid public-private structures (often referred to as public-private partnerships or PPPs) as an operational model to mobilize resources and commitment, in order to involve diverse groups of stakeholders through a horizontal governance model. The main purposes of the PPPs reflect the systemic gaps of global health: advocacy and coordination, financing of health interventions, and research and development of new medical products. Their institutional structures have coalesced around three main types: loose coordinating networks of actors engaged in the same activities; PPPs hosted by existing international organizations such as the WHO or the World Bank; and PPPs established as separate legal persons under national law. In general, form has followed function with financing PPPs requiring a more elaborate structure.

These new initiatives are normally established through administrative or private legal instruments despite the international nature of their functions and governance; hosted PPPs are created through charters or joint statements approved by the partners and ''linked'' to their host organizations through memoranda of understanding or terms of hosting approved by the board of the partnership. Their functioning undeniably contributes to the development of a growing body of global administrative law and is based on essentially voluntary commitments by the partners, raising questions of accountability both among the partners and to their common initiative.

PPPs have adopted a distinctly horizontal model of governance in order fully to include on an equal footing public and private participants and overcome the limitations encountered in this respect by ''traditional'' international organizations such as the WHO. An extreme example is the GAVI Alliance on vaccines and immunization, whose board is composed not only of NGOs and vaccine manufacturers, but is also one-third composed by individuals participating in their own right. One of the main purposes of creating ad hoc structures and initiatives has been the full involvement of commercial companies and philanthropic

* Legal Counsel, World Health Organization; Adjunct Professor, Graduate Institute of International and Development Studies, Geneva. The views expressed are solely those of the author.